U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 December 2003

CASE NO.: 2003-BLA- 163

In the Matter of

JEAN BALL o/b/o DORSEY LEE COVEY (Deceased),
Claimant

v.

OMAR MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS.
Party-in-Interest

Appearances:

Mary Rich Maloy, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on October 10, 2000, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The Claimant filed his first prior claim for benefits on April 25, 1973. (Director's Exhibit ("DX") 1). The claim was denied because the evidence failed to establish Mr. Covey had pneumoconiosis or was totally disabled due to pneumoconiosis. (DX 1). No further appeal was taken by the claimant.

The Claimant filed his second prior claim for benefits on July 23, 1985. (DX 2). The claim was denied because the claimant did not have pneumoconiosis. The Claimant requested a formal hearing in front of the Office of Administrative Law Judges. On April 3, 1990, Administrative Law Judge Chao issued a Dismissal Order, because Claimant exhibited a consistent pattern of not attending his hearings.

The Claimant filed the present claim for benefits on October 10, 2000. (DX 3). The claim was approved by the district director because the evidence established the elements of entitlement that Mr.Covey had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. (DX 26). On June 6, 2001, the Employer requested a hearing before an administrative law judge. (DX 27). The Claimant passed away on January 29, 2002. (DX 38). A hearing was scheduled for June 13, 2002 before Administrative Law Judge Lesnick. After being notified of Claimant's death, Judge Lesnick remanded the claim to inquire as to whether a survivor's claim would be filed. There are no dependants to file a survivors claim. Deloris Jean Ball, decedent's sister and executrix of his estate, has continued the case. (DX 39). On April 29, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on May 6, 2003.

On September 24, 2003, I held a hearing in Charleston, West Virginia, at which the employer was represented by counsel.[1] No appearance was entered for the Claimant or for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. No exhibits were admitted into the record. Thereafter, Jean Ball, the executrix of Claimant's estate, requested a decision on the record.

Post-hearing evidence consists of Employers Exhibits (EX) 1 through 12. The record also contains Director's Exhibits (DX) 1 through 45.

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 f.2D 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner was totally disabled?

IV. Whether the miner's disability was due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

The Claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 15 years. (DX 6).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on October 10, 2000. (DX 3). The timeliness of the filing is not contested.

C. Responsible Operator[2]

Omar Mining Company is the last employer for whom the Claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations. (DX 6).

D. Dependents

The Claimant has no dependents for purposes of augmentation of benefits under the Act.

[2] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

E. Personal, Employment and Smoking History[3]

The Claimant (decedent miner) was born on September 17, 1932. (DX 3). He married Janice Ball on September 9, 1952, and divorced on September 13, 1956. (DX 7; 8). The Claimant retired in 1987. He passed away on January 29, 2002. (DX 38). The Claimant's last position in the coal mines was that of a shuttle car operator. (DX 4).

He was employed in one or more underground mines for fifteen years or more. The Claimant, as part of his duties, was required to lift and carry 60 to 80 pounds. This job also consisted of dumping coal, sitting for eight hours, and standing for thirty minutes. (DX 25).

Claimant smoked a ½ pack per day from ages 16 through 58.[4] There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking.

II. Medical Evidence

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[5]

There were 17 readings of three X-rays, taken on November 14, 2000, March 17, 2001, and August 27, 2001. Four of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b).[6] Two are positive, by two physicians, Drs. Gaziano and Ranavaya,

[3] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[4] The evidence of Mr. Covey's smoking history is inconsistent. Dr. Dahhan initially notes a 20 pack year smoking history. Later, in the same report, he states that the Claimant never smoked. (DX 25). Dr. Ranavaya documents that Claimant never smoked. (DX 10). To clarify the issue, I looked at the evidence from Claimant's 1973 claim and 1985 claim. Dr. Attaii's exam on October 1, 1979, lists 20 years of smoking half a pack per day. (DX 1). Dr. Thavaradhara documents 30 years of smoking at the time of his exam, September 18, 1985. (DX 2). Thus, I conclude the weight of the evidence shows a 20 pack-year smoking history, as initially stated in Dr. Dahhan's report. (DX 25).

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[6] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

who are B-readers.[7] Fifteen are negative, by eleven physicians, all of whom are either B-readers, Board-certified in radiology, or both.[8]

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 12	11/14/00 6/12/02	Dr. Meyer	BCR, B	1		No radiographic evidence of CWP. Linear scarring at left lung base likely post-inflammatory or sequella of aspiration.
EX 11	11/14/00 3/27/02	Dr. Spitz	BCR, B	1		No evidence of CWP. Old healed fractures of the right fifth through ninth ribs. The heart and aorta are normal. The lungs and pleural spaces are normal.
EX 11	11/14/00 2/13/02	Dr. Wiot	BCR, B	1		No evidence of CWP. There are old healed fractures of the right fifth through ninth ribs.
EX 10	11/14/00 1/23/02	Dr. Scatarige	B	2 underexposure		Fractures right ribs 5-9. Discoid

[7] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

[8] *Cranor v. Peabody Coal Co.,* 21 B.L.R.1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on X-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						atelectasis, scarring left lower lobe. Barium residual in colonic diverticula.
EX 5	3/17/01 12/7/01	Dr. Kim	B, BCR	2 under-exposure		Multiple old healed fx. Rt.
EX 6	8/27/01 11/29/01	Dr. Wheeler	B, BCR	2 underexposure both PA views/ hyperinflation lungs one PA.		Chest PA – Normal except few subtle healed right possible rib fractures, minimal tortuosity descending thoracic aorta and possible few tiny linear scars in lower CPA's accentuated by underexposure on 2 PA views and subtle interlobe effusion or fibrosis in minor fissure and lower oblique fissures. No CWP.
EX 6	8/27/01 11/29/01	Dr. Scott	B, BCR	3 under-exposure		Few healed rib fractures on right.
EX 3	8/27/01 8/28/01	Dr. Willis	B, BCR	1	0/1	Parenchymal opacities with ILO classification of P/S in all lung zones and profusion of 0/1. No pleural

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						disease demonstrated. No acute cardiopulmonary disease.
EX 2	3/17/01 8/13/01	Dr. Wheeler	B, BCR	2 –under-exposure		Chest Pa – normal except few healed right posterior rib fractures. Light film accentuates pulmonary vascular prominence but there is no silicosis or CWP.
EX 2	3/17/01 8/7/01	Dr. Scott	B, BCR	2 under-exposure		Few healed rib fractures on right.
DX 24	11/14/00 5/22/01	Dr. Wheeler	B, BCR	2- under-exposure		No Evidence of CWP.
DX 24	11/14/00 5/21/01	Dr. Scott	B, BCR	2 under-exposure		No CWP.
EX 1	3/17/01 4/17/01	Dr. Zaldivar	B, BCI(P)	Blank	0/1	
DX 25	3/17/01 3/17/01	Dr. Dahhan	B, BCR	1		Completely negative.
DX 14	11/14/00 2/1/01	Dr. Gaziano	B	1	1/1	
DX 15	11/14/00 1/20/01	Dr. Navani	B, BCR	1	0/1	
DX 16	11/14/00 11/14/00	Dr. Ranavaya	B	1	1/0	

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the

presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co*., BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[9]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician **Date** **Ex.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehension** **Cooperation**	**Qualify *** **Conform****
Dr. Crisalli 8/27/01[10] EX 3	68 66.5 in.	1.91	59	3.58	Yes	Good Good	No Yes
Dr. Dahhan 3/17/01 DX 25	68 64.9 in.	1.55		2.72	Yes	Poor Good	No Yes
Dr. Dahhan 3/17/01 DX 25 After Bron.	68 64.9 in.	1.71		3.44	Yes	Poor Good	No Yes
Dr. Ranavaya	68 65 in.	1.81	41.9	3.03	Yes	Fair Fair	No Yes

[9] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

[10] Report states: "Bronchodilator studies not done due to the patient stating that albuterol made his heart 'race' and his doctor had taken him off the albuterol." (EX 3).

Physician **Date** **Ex.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehension** **Cooperation**	**Qualify *** **Conform****
11/14/00 DX 12							
Dr. Ranavaya 11/14/00 DX 12 After Bron.	68 65 in.	1.98	50.4	3.15	Yes	Fair Fair	No Yes

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 65.4 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.56 for a male 68 years of age.[11] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.02 or an MVV equal to or less than 62; or a ration equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ration requirement remains constant.

[11] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 65.4" here, his average reported height.

Height	Age	FEV_1	FVC	MVV
64.6	68	1.49	1.94	60
65.0	69	1.51	1.96	60
66.1	68	1.62	2.09	65

On September 26, 2001, Dr. Crisalli, who is board certified in pulmonary diseases and internal medicine, completed a diffusion study. (EX 4). The DL/VA is 2.34 and the VA is 5.24. Dr. Crisalli found that Mr. Covey's diffusion capacity showed a severe defect. He stated that the diffusion abnormality is related to the Claimant's emphysema. (EX 4).

C. Arterial Blood Gas Studies[12]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
8/27/01 EX 3	Dr. Crisalli	43	60	Yes	
3/17/01 DX 25	Dr. Dahhan	40	62.4	No	
11/14/00 DX 11	Dr. Ranavaya	34	65	Yes	No exercise blood gas study was done due to resting arterial blood gas meeting US federal criteria for total disability as contained in 20 CFR 718.

[12] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Castle is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary diseases. His consultation report, based upon his review of the medical records of the claimant, on December 4, 2001, notes 20 years of coal mine employment and more than a 20 pack-year smoking history. (EX 7).

Based on arterial blood gases, a pulmonary function study, and chest X-rays, Dr. Castle diagnosed that Mr. Covey did not suffer from coal workers' pneumoconiosis.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Castle stated that Claimant's smoking history was "significant enough exposure to have caused him to develop chronic obstructive pulmonary disease, i.e. chronic bronchitis/emphysema and/or lung cancer and/or atherosclerotic cardiovascular disease if he were a susceptible host." (EX 7). He also stated that Claimant's coronary artery disease was another risk factor for the development of pulmonary symptoms.

Dr. Castle also explained that the moderate degree of airway obstruction with hyperinflation, gas trapping, and diffusion reduction shown by the pulmonary function studies is consistent with a diagnosis of tobacco smoke induced pulmonary emphysema. (EX 7). He stated that the findings of the pulmonary function studies are not what would be expected in someone with coal workers' pneumoconiosis.

Dr. Castle found that Mr. Covey was disabled from a pulmonary point of view from performing his usual coal mine employment. However, he finds that his disability was neither caused in whole or in party by coal workers' pneumoconiosis or his coal dust exposure.

Dr. Rosenberg is a B-reader and is Board-certified in pulmonary disease, internal medicine, and occupational medicine. His consultation report, based upon his review of the medical records of the claimant, on December 4, 2001, notes 25 years of coal mine employment and a smoking history. (EX 8). Dr. Rosenberg described the claimant's symptoms as cough, congestion, and shortness of breath.

Based on a review of the medical records, Dr. Rosenberg diagnosed significant chronic obstructive pulmonary disease related to his long smoking history. Dr. Rosenberg concluded that Mr. Covey's impairments would have rendered him disabled from performing his last coal mining job.

He opined that the Claimant's pulmonary condition was not related to his coal dust exposure. The medical evidence shows the presence of emphysema, not coal workers' pneumoconiosis. Dr. Rosenberg stated that it is clear that Mr. Covey had obstructive lung disease. However, he stated that there was reversibility, which is not characteristic of pneumoconiosis. As such, Dr. Rosenberg concluded: "Undoubtedly, Mr. Covey's obstructive lung disease is related to his past smoking history." (EX 8).

Dr. Crisalli is Board-certified in pulmonary and internal medicine. His examination report, based upon his examination of the Claimant, on August 27, 2001, notes 34 years of coal mine employment. Dr. Crisalli indicates that there are varying degrees of cigarette smoking in Claimant's records. The studies vary from five years of smoking to forty years to indicating that he never smoked. (EX 3). Dr. Crisalli described the claimant's symptoms as shortness of breath, cough productive of sputum, and chest pain. Dr. Crisalli noted that Mr. Covey had to stop three times to catch his breath walking from the parking lot to Dr. Crisalli's office. Mr. Covey's medical history includes coronary artery disease and leukemia. Mr. Covey was unable to take chemotherapy. (EX 3).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Crisalli diagnosed emphysema and chronic bronchitis. He found no evidence of coal workers' pneumoconiosis. An exercise blood gas was not performed because of Claimant's cardiac disease.

He opined that the claimant's pulmonary condition was not related to his coal dust exposure. Dr. Crisalli stated that Mr. Covey had "pulmonary function impairment which is secondary to his emphysema." He found that Mr. Covey's impairment would have prevented him from returning to his previous jobs in the coal mine. He stated that Mr. Covey's impairment was not in any way related to coal dust exposure.

Dr. Dahhan is a B-reader and is Board-certified in pulmonary and internal medicine. His examination report, based upon his examination of and review of the medical records of the claimant, on March 17, 2001, notes 34 years of coal mine employment and a 20 pack year smoking history. (DX 25). Dr. Dahhan described the claimant's symptoms as daily cough with productive yellowish sputum with no hemoptysis. Claimant had an occasional wheeze. Claimant claimed dyspnea on exertion.

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray, Dr. Dahhan found insufficient objective data to justify a diagnosis of pneumoconiosis. Dr. Dahhan diagnosed an obstructive ventilatory defect.

He opined that the Claimant's pulmonary condition was not related to his coal dust exposure. Dr. Dahhan stated: "Mr. Covey's obstructive ventilatory defect has resulted from his

smoking habit of 20 pack years, an amount sufficient to cause the development of such a defect in a susceptible individual." (DX 25).

Dr. Ranavaya is a B-reader. His examination report, based upon his examination of the claimant, on November 14, 2000, notes 34 years of coal mine employment and no smoking history. (DX 10). Dr. Ranavaya described the claimant's symptoms as sputum, wheezing, dyspnea, cough, chest pain, orthepnea and paroxysmal nocturnal dyspnea. The miner also complained of shortness of breath on mild to moderate exertion.

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed pneumoconiosis. Dr. Ranavaya also diagnosed coronary artery disease and hypertension based upon the miner's medical history. (DX 10).

He opined that the claimant's pulmonary condition was related to his coal dust exposure. Dr. Ranavaya stated the etiology as "occupational exposure to dust in coal mining for 34 years." (DX 10).

III. Witness' Testimony

Dr. Castle was deposed on December 18, 2001. As stated above, Dr. Castle is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary diseases. (EX 9; pp. 4-5). Dr. Castle testified that Claimant worked in the coal mines for 34 years, which is a sufficient time for a susceptible individual to develop coal workers' pneumoconiosis. (EX 9; pp. 10-11).

Dr. Castle was questioned about the validity of pulmonary studies. Dr. Castle testified that Dr. Dahhan's pulmonary evaluation was not technically a valid study:

> Q: And now, the next study done in conjunction with Doctor Dahhan's evaluation, the cooperation was listed as poor on that one.
>
> A: Yes.
>
> Q: Would you agree that looking at the tracings, that it was not technically a valid study?
>
> A: That study showed a significant degree of variability. He did not have reproducible results, but you could say that there was some degree of airway obstruction. I couldn't actually accurately quantitate that degree of obstruction, so I – and I thought that the study was invalid. The lung volumes were invalid and the diffusing capacity was invalid as well.

(EX 9; p. 12). Dr. Castle testified that the studies performed by Dr. Ranavaya and Dr. Crisalli were valid studies. He stated that the results of Dr. Ranavaya's study showed a mild airway obstruction. (EX 9; p.11). Dr. Crisalli's results showed moderate airway obstruction, significant gas trapping and hyperinflation of the total lung capacity. Dr. Castle stated that these findings are indicative of tobacco smoke induced pulmonary emphysema. (EX 9; p. 13). Dr. Castle testified that between 1985 and 2001, Mr. Covey's impairment went from mild obstruction to

moderate obstruction. (EX 9; p. 15). Such changes took place after Mr. Covey left the mining industry, while he continued to smoke.

Dr. Castle explained that tobacco smoke-induced pulmonary emphysema creates a loss of alveolar surface area. Patients with chronic bronchitis do not have destruction of the alveolar sacs. Mr. Covey had a reduction in his diffusing capacity, which means he had a loss of alveolar sacs. (EX 9; p. 14). Dr. Castle stated that the blood gas tests showed a mild degree of hypoxemia, which is consistent with Mr. Covey's degree of obstruction.

Dr. Castle defined pulmonary emphysema and chronic bronchitis:

Q: Would you define pulmonary emphysema:

A: Pulmonary emphysema is a diagnosis that is basically based on the pathologic description of the destruction of lung tissue, including alveolar sacs and capillary beds, involving the pulmonary lobule, everything from the respiratory bronchial out to the alveolar sacs. It is a condition that is clinically manifested by physiologic function showing obstruction with hyperinflation, gas trapping, and reduced diffusion capacity. Chronic bronchitis, which is the other portion of chronic obstructive pulmonary disease, is defined clinically with a person having a chronic cough with sputum production for three months out of the year for at least two consecutive years. As I said, pulmonary emphysema has been defined as a pathologic condition rather than as a clinical syndrome.

Q: Are these the same physiologic findings that you would see in an individual who has impairment as a result of coal dust exposure?

A: No, it is not. First of all, in pulmonary emphysema, we see obstruction, but it is associated, as I said, with hyperinflation and gas trapping with a reduced diffusion capacity. In coal workers' pneumoconiosis, where there is impairment, we generally see a mixed irreversible obstructive and restrictive ventilatory impairment.

(EX 9; pp. 20-21). Dr. Castle explained that the diffusion capacity is very rarely reduced in people with coal workers' pneumoconiosis. Mr. Covey had a very significant reduction in the diffusing capacity. Dr. Castle concluded that Mr. Covey had no evidence of restrictive lung disease.

Dr. Castle discussed the discrepancies in Mr. Covey's smoking history. He concluded that Mr. Covey had pure tobacco smoke-induced pulmonary emphysema. He also found that "Mr. Covey is probably disabled based on the degree of pulmonary emphysema that he has due to cigarette smoking." (EX 9; p. 29).

Dr. Castle did not find coal workers pneumoconiosis:

Q: And in your medical opinion, Doctor, does Mr. Covey have coal workers' pneumoconiosis?

A: No, sir, he does not. He does not in my opinion have the physical findings, the radiographic findings, or the physiologic findings to indicate the presence of coal workers' pneumoconiosis.

(EX 9; p. 29). Dr. Castle confirmed that Mr. Covey has neither legal nor medical pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), *citing Greenwhich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Since this is the claimant's third claim for benefits, and it was filed before January 19, 2001, under the old regulations, he must initially show that there has been a material change of conditions.[13]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of April 3, 1990, i.e., disability due to the disease.[14] *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative

[13] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part…[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions…
> (Emphasis added).

[14] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition, under 20 C.F.R. § 725.309, absent corroborating medical evidence.

Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's first application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 1; 2). The Claimant's second application for benefits was dismissed for failure to appear. Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

As will be discussed below, the Claimant has proven a material change in conditions regarding the element of total disability.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[15] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[16]

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[15] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[16] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers'

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[17] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[18] 20 C.F.R. § 718.202(a)(4).

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pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[17] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[18] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented"

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."*Id .; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990).This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31, 1-37 (1991).

This record contains multiple conflicting interpretations by various well-qualified B-readers and/or Board-certified radiologists. Therefore, I find that the X-ray evidence neither precludes nor establishes the presence of pneumoconiosis.

I find the August 27, 2001 X-ray negative for pneumoconiosis, because three dually qualified physicians made a negative reading and no positive reading was submitted. In addition, I find the March 17, 2001 X-ray negative for pneumoconiosis, because four dually qualified physicians and a physician who is Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader made a negative reading and no positive reading was submitted. Moreover, I find the November 14, 2000 X-ray negative for pneumoconiosis, since

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(medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

six dually qualified and one B-reader issued a negative reading and two B-readers issued a positive reading.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[19] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

As outlined above, the case file includes the medical opinion of Drs. Castle (EX 7), Rosenberg (EX 8), Crisalli (EX 3), Dahhan (DX 25), and Ranavaya (DX 10). It also includes the deposition transcript of Dr. Castle. (EX 9).

Dr. Ranavaya is a B-reader. He performed the Department of Labor exam and made a diagnosis of pneumoconiosis based on 34 years of occupational exposure to dust in coal mining and radiological evidence of it. Based on the claimant's history, Dr. Ranavaya also diagnosed coronary artery disease and hypertension. Dr. Ranavaya stated that the moderate impairment rendered Claimant totally disabled.

Dr. Ranavaya stated that claimant chewed tobacco since 1990, but never smoked. Other evidence in the record shows an extensive smoking history. This leads to the question of whether Dr. Ranavaya's diagnosis would change if he were aware of such a smoking history. Furthermore, Dr. Ranavaya diagnosed coronary artery disease, but does not state what effect this has, if any, on Claimant's pulmonary impairment. In view of the foregoing, I accord little weight to Dr. Ranavaya's opinion. Dr. Ranavaya's opinion is not well-reasoned in that he does not explain, other than stating over 34 years of coal mine employment and a positive chest X-ray (which was later read by dually qualified physicians as negative), why the evidence leads to a diagnosis of pneumoconiosis.[20]

Dr. Castle, Board-certified in internal medicine with a subspecialty in pulmonary diseases, did not find coal workers' pneumoconiosis. He did find a totally disabling pulmonary

[19] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

[20] In *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4).

impairment. Dr. Castle noted 20 years of coal mine employment and a 20 pack-year smoking history. He concluded that Mr. Covey's smoking history and coronary disease contributed to his pulmonary symptoms. Dr. Castle explained that the pulmonary function studies displayed results that are consistent with tobacco smoke induced pulmonary emphysema, not coal workers' pneumoconiosis.

Dr. Castle discussed how Mr. Covey's symptoms and medical evidence relate to a tobacco smoke induced pulmonary impairment. During a deposition, Dr. Castle stated that Mr. Covey had a loss of the alveolar surface area. He explained that such evidence shows a tobacco smoke-induced pulmonary impairment. Moreover, Dr. Castle stated that a reduction in diffusion capacity, which was found in Mr. Covey, is rare with patients who have coal workers' pneumoconiosis. Thus, Dr. Castle provided a well-reasoned basis for concluding that Mr. Covey does not have pneumoconiosis. I find Dr. Castle's opinion to be more credible than Dr. Ranavaya.

Dr. Rosenberg concluded that Mr. Covey had emphysema, not coal workers' pneumoconiosis. Through reviewing the medical evidence, Dr. Rosenberg found that Mr. Covey's obstructive lung disease did not develop until years after his coal mining work ceased. He also explained that the reversibility found on the pulmonary function tests is not a characteristic of coal workers' pneumoconiosis. Dr. Rosenberg did conclude that Mr. Covey's impairment was totally disabling. Dr. Rosenberg reasoned that the negative chest X-rays, the claimant's smoking history, the late development of the lung disease, and the reversibility lead to a significant chronic obstructive pulmonary disease related to his long smoking history. In view of the foregoing, I find Dr. Rosenberg's opinion more credible than Dr. Ranavaya's opinion.

Dr. Crisalli is Board-certifed in internal medicine and pulmonary disease. He based his report on an examination of Claimant. In addition, he did an extensive review of Claimant's medical records. Dr. Crisalli noted the discrepancies in Claimant's smoking history. Dr. Crisalli concluded that Mr. Covey had evidence of emphysema based on the air trapping noted on his pulmonary function study. He did not find any evidence of coal workers' pneumoconiosis. Dr. Crisalli did conclude that Mr. Covey's pulmonary impairment was disabling. I find that through review of the medical records and an examination of the Claimant, Dr. Crisalli provided a reasoned and well-documented opinion regarding Mr. Covey's breathing impairment. Therefore, I find Dr. Crisalli's opinion to be more credible than Dr. Ranavaya.

Dr. Dahhan is Board-certified in internal medicine and pulmonary disease. He based his opinion on an examination of the Claimant and a review of the medical records. Dr. Dahhan diagnosed an obstructive ventilatory defect. He explained that Mr. Covey's defect resulted from his smoking history and not coal dust exposure. He based his conclusion on a clinical examination of the chest, the response to bronchodilator therapy and negative chest X-ray readings. The obstructive ventilatory defect was demonstrated by physiological studies. In addition to claimant's smoking history, Dr. Dahhan explained that Mr. Covey's treatment with a Beta Blocker caused airway obstruction. He did find that Mr. Covey's respiratory impairment was disabling. Dr. Dahhan's opinion is reasoned and well-documented. It is more credible than Dr. Ranavaya's opinion.

A general disability determination by a state or other agency is not binding on the Department of Labor with regard to a claim field under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder.[21] *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a "15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Thus, I give the state determination some weight as to the existence of pneumoconiosis. Claimant filed a claim for Workers' Compensation benefits due to pneumoconiosis or other chronic lung disease and was approved at 15%. (DX 5).

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). Taken as a whole, the X-ray evidence and medical opinions, do not establish the presence of pneumoconiosis.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).[22]

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[23] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish

[21] See § 718.206 "Effect of findings by persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000) (Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

[22] Specifically, the burden of proof is met under § 718.203(c) when "competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987).

[23] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. Fro purposes of this section, any nonpulmonary or nonrespiratory condition or

total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993).

Three doctors performed pulmonary function studies. None of these studies produced qualifying results. Thus, the Claimant did not prove total disability based on the results of pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

Three blood gas studies were performed. Two of the studies produced qualifying results. Therefore, I find that the blood gas studies establish total disability.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare

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disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The record includes the medical opinions of Drs. Castle (EX 7), Rosenberg (EX 8), Crisalli (EX 3), Dahhan (DX 25), and Ranavaya (DX 10). These physicians are in agreement that Claimant's pulmonary impairment is sufficient to disable him from performing his last coal mine work.

Based on the blood gas studies and the physician opinions, I find the Claimant is totally disabled. I find that the miner's last coal mining positions required heavy manual labor. Therefore, I find he is incapable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 f.3D 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 f.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).[24]

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability[25]

[24] The Board recently held that its earlier statement, in *Carson*, that "The disabling loss of lung function due to extrinsic factors, e.g., loss of muscle function due to stroke, does not constitute respiratory or pulmonary disability pursuant to 20 C.F.R. § 718.204(c)," was incorrect and struck the language from its opinion. *Carson v. Westmoreland Coal Co.*, 20 B.L.R. 1-64 (1996), *mod'g on recon.*, 19 B.L.R. 1-16 (1994).

[25] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

The revised regulations, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability.[26] The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) an d(ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis isa substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).[27]

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[28] *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respirator or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking.[29] However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger*

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[26] This standard is more consistent with the Third Circuit's pre-amendment "substantial contributor" standard set forth in *Bonessa v. U.S. Steel Corp*., 884 F.2d 726, 13 B.L.R. 2-23 (3d Cir. 1989) than the Fourth Circuit's "contributing cause" standard set forth in *Robinson v. Picklands Mather & Co./ Leslie Coal Co. v. Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35, 38 (4th Cir. 1990).

[27] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[28] *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L..R 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or 'substantial' cause." *Id.*

[29] *Sewell Coal Co. v. Director, OWCP [O'Dell]* (Unpublished), 22 B.L.R. 2-213, No. 00-2253 (4th Cir. July 26, 2001)(Unpublished). "…the mere documentation of a smoking history on the official OWCP form or elsewhere, without more, cannot reasonably imply that an examining physician has 'addressed the possibility that cigarette smoking caused the claimant's disability." *Malcomb v. Island Creek Coal Co.*, 15 F.3d 364 at 371 (4th Cir. 1994).

Coal Co., 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally*, *Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Picklands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).

According to the blood gas studies and the medical opinions, I find that claimant has established that he suffers from a total pulmonary or respiratory disability. This, in turn, represents a material change in conditions under 20 C.F.R. § 725.309. However, since Claimant has not established (clinical or legal) pneumoconiosis by a preponderance of the evidence, he has also failed to establish total disability due to pneumoconiosis, as defined in § 718.204(c). Moreover, the medical evidence establishes that Claimant's disability was not occupationally acquired, and that is unrelated to coal mine dust inhalation.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the Claimant has established that a material change in condition has taken place since the previous denial, because he was disabled prior to his death. The Claimant did not have pneumoconiosis, as defined by the Act and Regulations. The Claimant was totally disabled. His total disability was not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER

It is ordered that the claim of Mr. Covey for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[30]

[30] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.